

Hospital Palliative Care Advisory Group
Patient Definition and Discharge Database Subcommittee
Summary of Discussions on February 25 and March 4, 2014

Attendance: Yvonne D'Arcy; Joan Daugherty; Cathy Hamel/ Tara Holicky; Jaya Vijayan; Katherine Walker

MHCC Staff: Linda Cole; Rebecca Goldman; Paul Parker

Introduction

Rebecca Goldman reminded the members of the subcommittee that this is one of the four subcommittees identified by the Advisory Group at its last meeting. This is the first meeting of the Definition/Discharge Database Subcommittee, which MHCC Staff feels is a priority issue to address at this time. The charge for this subcommittee is to define the patient population for the pilot study, as well as how to address data issues including flagging data for extraction from the HSCRC discharge data set.

Definition issues

Definition of palliative care patients for this project

Kathryn Walker noted that the V66.7 (V-Code) is not specific enough for a definition. While palliative care patients are included in the V-code, other types of patients who are not appropriate for palliative care team referrals may also be included.

Paul Parker indicated that the aim is to flag patients who are discharged from the pilot hospitals who represent the patient population served by a palliative care program for a set period of time. This subcommittee can help to define a standard set of rules that defines those patients served by palliative care programs, with which all pilot hospitals can agree. If this can be done, then MHCC can meet with data coordinators to determine how best to flag them.

Ms. Walker explained that MedStar Union Memorial tracks all patients. Instead of a prospective study, she asked whether the project could use retrospective data. She believes the samples or populations represented in any six-month period should reflect the same types of patients – very complex issues, frequent readmissions, high numbers of comorbidities, patients who are expected to die within the next year, etc.

The group also discussed whether data could be collected on patients that are served in outpatient services and services outside of the hospital. Mr. Parker stated that, while that would be ideal and that we could also establish a small group to approach that issue, the immediate focus should be on defining the hospital palliative care patient and how to best collect that information. Additionally, he believes it would be best to have a standard set of data flagged prospectively for at least one year. However, if retrospective data was available, this could be useful as well.

Ms. Walker believes that each program defines their patients differently, but that the project should flag palliative care patients, not what the palliative care program does for the hospital that involves other tasks. All others agreed. All pilot hospital members also agreed that patients become palliative care patients at the time of initial consultation, whether or not they decide to move forward under the palliative care team's treatment plan. Possible definitions may revolve around frequent readmissions, functional decline,

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quality of life, life-limiting condition or event, advanced progressive disease, or families facing a crisis. To sum up those concepts, as well as leave a little room or interpretation at each different pilot hospital site, she suggested we might focus on the concept of “*life-limiting illness or event*”. Other pilot hospitals agreed with this summation.

Definition of potential palliative care patients

Cathy Hamel posed the question regarding whether this project should also look at the “potential population” or the population actually served. MHCC staff agreed that this project should include both those populations. Yvonne D’Arcy suggested that the potential population could be estimated by using the Top 15 DRGs as defined by CAPC as “potential patients.” Jaya Vijayan added that not all who meet the criteria of palliative care are ever sent or referred to the palliative care program staff. Ms. D’Arcy added that it will be helpful to know and compare who are potential patients and who is seen. Joan Daugherty also believes it is important to understand both the potential patient populations and the patients served.

Both Ms. D’Arcy and Ms. Vijayan volunteered to send MHCC Staff some literature to review on these topics.

Outcome of the Subcommittee to date

MHCC Staff reviewed the literature forwarded by Ms. D’Arcy and Ms. Vijayan to draft a definition. The group reconvened by phone to edit and finalize a definition. The group agreed upon the following definition, which will be presented to the full stakeholder group at the next meeting:

Identification of Hospital Palliative Care Patient Population in the HSCRC Discharge Data Base

The Maryland Health Care Commission (MHCC), as part of a study of hospital palliative care programs, is requesting that participating pilot hospitals identify and flag their palliative care patient discharges in the HSCRC Discharge Data Base, so that the hospital experience of this patient population can be described and quantified.

General Guideline for Flagging of Discharges:

Flag all patients who were referred to the hospital palliative care program and obtained a palliative care consultation to address serious, complex, and potentially life-limiting or life-threatening conditions.

Next Steps: Use of HSCRC discharge database for patient information collection

MHCC Staff will meet with Ms. Walker and MedStar Union Memorial data staff, who have volunteered to have a detailed conversation about how HSCRC data could be linked to that location’s palliative care data. Depending on the outcome of this initial meeting, as well as systems in place at all other pilot hospitals, MHCC Staff may initiate similar conversations at the other nine pilot locations.